<u>New Client Questionnaire</u>

Congratulations on your decision to participate in an exercise program and/or Muscle Activation Techniques ("MAT") sessions! With my help you will greatly improve your ability to accomplish your goals faster, safer, and with maximum benefits! The details you share below are of great importance for our treatment(s) and work together.

Please take your time to fill out this form and please offer thorough answers to the questions contained herein. Thank you!

Name: ____

Address: ____

Email: ________________________________ Phone Number: ___________________

Gender: _________ DOB: ______________ Age: __________

Emergency Contact Person: ______________________ Phone Number: ______________

Relationship to You: ____________________________ Their Email: __________________

1. Briefly describe your present complaint(s):

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2. What quantitative (run 5 miles) and/or qualitative (feel stronger) outcome(s) would you like from our work with together:

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3. Please list any questions or concerns you have regarding the MAT process:

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4. Please list any recent diagnostic procedures you have had (X-Ray, MRI, CT-Scan, etc.) below:

Diagnostic Procedure	Date	Physician

5. Please list all surgeries you have had, please give specific procedures, dates, and surgeon's name if possible:

Surgical Procedure	Date	Physician

6. Do you receive or have you had any cosmetic and/or plastic surgery (botox, tummy tucks, face lifts, breast implants, etc.)?

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7. Have you ever had or do you currently have (cross off the following that apply to you):

High Blood Pressure	Fibromyalgia	High Cholesterol	Chronic Fatigue Syndrome	Heart or Circulation Disorders	Lupus
Family History of Heart Disease	Lyme Disease	Smoking History	HIV/AIDS	Asthma	Thyroid Condition
Cancer	Ulcerative colitis	SIBO, Crohn's Disease	IBS	Epilepsy or Seizure Disorder(s)	Rheumatoid Arthritis
Osteoarthritis	Urinary Incontinence	Scoliosis	Female Reproductive Issues	Spinal Fusions	Hernia
Joint Swelling or Stiffness	Whiplash	Osteoporosis	Migraines	Anxiety	Learning Disabilities or Cognitive Challenges
Food Allergies or Sensitivities	Pelvic Floor Issues	Fainting Spells	Vertigo	Depression	Concussions

8. Please list all medications (medically and self-prescribed), dietary supplements, and/or herbs that you are currently taking:

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9. Have you ever been in an automobile accident, motorcycle accident, bike accident, minor fender bender or major fall? Please list, share the date(s) and/or explain further:

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10. Do you participate in any other healing or fitness modalities? If yes, please list name/practice & frequency of your visits per month:

Practice	Name of Practice / Specialist?	Frequency	Practice	Name of Practice / Specialist?	Frequency
Physical Therapy			Chiropractic Care		
Acupuncture			Massage		
Personal Training / Group Fitness			Active Release Techniques		
Cranio-Sacral Work			Pilates		
Yoga			Other		

11. Do you currently treat, manipulate or adjust yourself in any therapeutic ways that you find to be helpful? Please let me know.

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12. Do you wear glasses or contacts? Do you have astigmatism?

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13. Mouth and jaw issues? Please fill out any that apply:

- Do you have any fillings/crowns? ____________________________________
- If yes, what are they made out of? ____________________________________
- Have you had any oral surgeries? ____________________________________
- Does your jaw snap, click, or pop? ____________________________________

14. What are you wearing on your feet? Please let me know below:
   - Do you wear orthotics or insoles (past or present)?___________________________________
   - Do you wear flip-flops daily or on weekends?_______________________________________
   - Do you wear heels higher than 1⁄4 inch weekly?_____________________________________

15. For Women, please fill out the below if it applies to you:
   - Are you currently pregnant? If yes, how far along? ___________________________________
   - Have you had any miscarriages or stillbirths?_______________________________________
   - If you have children, how many? ____
   - Were the births vaginal or cesarean? ____
   - During birth, did you use medications such as an epidural or pitocin?

   ____
   - Were there any complications during delivery?

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16. Please inform me about your sleep habits:
   - How many hours do you sleep per night? ____
   - Is it difficult to fall asleep? ____
   - Which best describes you? Circle any of the below.
   - When you wake you feel ready to tackle the day?
   - Do you often feel like you could sleep 1-2 hours more no matter how much sleep you've gotten?
   - Do you get up frequently at night, and/or toss and turn?

17. Would you rate your weekly stress level as low, medium, or high?__________________________

18. What do you do for yourself to manage stress? How do you deal with high stress situations?

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19. Let's discuss your work environment and habits, please circle the answer that applies:
   - Is your work-station ergonomically correct Y / N
   - Have you had it professionally evaluated? Y / N
   - Do you have a sit / stand desk? Y/N
   - Do you use a headset when talking on the phone? Y / N

20. Do you have any lifestyle habits or obstacles that may make it difficult for your body to adapt to the changes that we are trying to make (staying up late, yo-yo exercising, addictions or inflammation)?

21. Is there anything else that you would think may be relevant that needs to be discussed?

23. Describe your current or recent exercise history (past 6-12 months). What activities do you enjoy, partake in with regularly (or in the recent past)?